

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH
County Andram
Township Cuisse
or
Village Farber
or
City _____ (NO. _____ St. _____ Ward _____)

Registration District No. 24
Primary Registration District No. 52033

File No. 13401
Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Amanda Melvina Adams

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White SINGLE MARRIED WIDOWED OR DIVORCED widowed
(If wife the word)

DATE OF BIRTH Aug 8, 1886
(Month) (Day) (Year)

AGE 79 yrs. 7 mos. 23 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
(City or town, State or foreign country) Ky.

PARENTS
NAME OF FATHER John Summers
BIRTHPLACE OF FATHER Ky.
(City or town, State or foreign country)
MAIDEN NAME OF MOTHER Matilda Summers
BIRTHPLACE OF MOTHER Ky.
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr Adams
(ADDRESS) Harribal Mo

Filed Apr. 6, 1916, J. M. Morrow
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Mar 31, 1916
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from Jan 10, 1916, to 3-31, 1916, that I last saw her alive on 3-31, 1916,

and that death occurred, on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
97 81

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Ascites
(SECONDARY) (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. K. McEgall M. D.
4-1- 1916 (Address) Laddonia Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted? Laddonia Mo
If not at place of death?

Former or usual residence Laddonia Mo

PLACE OF BURIAL OR REMOVAL Harber, Mo DATE OF BURIAL Apr 3, 1916

UNDERTAKER W. G. Cronin ADDRESS Laddonia Mo

PLACE OF DEATH

County _____
 Township _____
 or
 Village _____
 or
 City _____ (NO. _____)

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____

FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
DATE OF BIRTH	(Month) _____ (Day) _____ (Year) _____	
AGE	(Month) _____ (Day) _____ (Year) _____	IF LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
 (a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE
 (City or town, State or foreign country) _____

NAME OF FATHER
 (City or town, State or foreign country) _____

BIRTHPLACE OF FATHER
 (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER
 (City or town, State or foreign country) _____

BIRTHPLACE OF MOTHER
 (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____ 191 _____ REGISTRAR

MISSOURI STATE BOARD OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

Registration District No. _____ File No. _____
 Primary Registration District No. _____ Registered No. _____
 St. _____ Ward _____

[If death occurred in hospital or institution, give its NAME instead of street and number.]

TH

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH
 (Month) _____ (Day) _____ (Year) _____

I HEREBY CERTIFY, that I attended deceased from _____, 191 _____, to _____, 191 _____, that I last saw him alive on _____, 191 _____, and that death occurred, on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows:

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory

(SECONDARY)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D.

(Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, state of Injury and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OF RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191 _____

UNDERTAKER

ADDRESS

SS

OF BURIAL

191 _____

OF HEALTH
 STATISTICS
 TH

PARENTS

Violent Causes, state of Injury and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OF RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ ds.

Where was disease contracted if not at place of death?

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

191 _____

UNDERTAKER

ADDRESS

SS

OF BURIAL

191 _____